EMT REINSTATEMENT REPORTING FORM

SECTION 1: EMT-BASIC REFRESHER TRAINING – 24 hours*

*Certification of completion of the 1994 National Standard EMT Basic Refresher Course

DATE	DIVISION	MAND. HOURS	HOURS RECEIVED	DATE	DIVISION	MAND. HOURS	RECEIVED
	Disaster Mangmnt	1			Trauma	4	
	Airway	2			O.B. Infants & children	2	
	Pt. Assessment	3			Electives	6	
	Med/Behavioral	4			**Aids Education	2	
					TOTAL HOURS	24	

**Must provide certificate with KY CHS Approval #

SECTION II: CPR*(SUBMIT COPY OF CPR CARD OR VERIFY WITH APPROPRIATE SIGNATURE BELOW)

As the applicant's CPR instructor/training officer, I hereby verify the applicant has been examined and performed satisfactorily so as to be deemed competent in each of the following:

Adult:
1 & 2 Rescuer CPR
Obstructed Airway

Child:
1 & 2 Rescuer CPR
Obstructed Airway

Infant:
CPR
Obstructed Airway

_____ / / _____

CPR Instructor/Training Officer Signature Date Expiration Date

_____ / _____

Printed Name of CPR Instructor/Training Officer Signature Training Agency

SECTION III: VERIFICATION OF SKILL MAINTENANCE (INDICATE METHOD USED)	Q/A* Q/I*	DIRECT OBSERVATION	(EXAM) OTHER METHOD
1. PATIENT ASSESSMENT/MANAGEMENT: Medical & Trauma			
2. VENTILATORY MANAGEMENT SKILLS/KNOWLEDGE: Simple adjuncts Supplemental Oxygen Delivery Bag Valve-Mask One-rescuer Two-rescuer			
3. CARDIAC ARREST MANAGEMENT: Automated External Defibrillator (AED)			
4. HEMORRHAGE CONTROL & SPLINTING PROCEDURES			
5. SPINAL IMMOBILIZATION: Seated and lying patients			
6. OB/GYNECOLOGIC SKILLS/KNOWLEDGE			
7. OTHER RELATED SKILLS/KNOWLEDGE: Radio communications Report writing & documentation			

Q/A* Quality Assessment ; Q/I Quality Improvement*

As the EMT-Basic Training Program Director, Service Director of Training/Operations or the Physician Medical Director of Training Operations, I do hereby affix my signature attesting to continued competence in all skills outlined in Section III.

PRINTED NAME SIGNATURE

_____ / _____ _____

Training Program Director*, Service Director of Operations* or Physician Medical Director* Title (Clarify if title is other than provided by examples)

_____ / _____ / _____

Name of Agency Represented By Director or Other Title Phone # for contact between 8-4:30 pm Date

(Note: If the Director is a renewal candidate, they may not sign for themselves.)*

I hereby affirm that all statements on this EMT-Basic (Renewal) Report are true and correct, including the copied cards, certificates and other required verification. It is understood that false statements or documents may be sufficient cause for revocations by the Cabinet for Health Services – EMS Branch. It is also understood that the KY EMS Branch may conduct an audit of the renewal verification records listed at any time.

_____ / _____ / _____

Printed Name of Renewal Candidate Signature KY EMT-B Cert. # Date